PROVIDER DOCUMENT REQUESTS

PROVIDER INFORMATION

Attention: _____ Billing Company Name _____ Phone # _____

Facility Name (*Required*) _____ Provider Contract Number or NPI (*Required*) _____

Address (*Required*) _____ Suite _____

City (*Required*) _____ State (*Required*) _____ ZIP Code (*Required*) _____

Email Address _____

☐ **Remittance Request** (One Provider Per Worksheet)

**If the Remittance Request is being sent US Mail and is over 25 pages, then a charge of $0.12 will be charged to each additional page. Payment must be received before the remittance will be sent out.

Run Date (*Required*) _____ Amount (*Required*) _____ Run Date (*Required*) _____ Amount (*Required*) _____

Run Date (*Required*) _____ Amount (*Required*) _____ Run Date (*Required*) _____ Amount (*Required*) _____

Run Date (*Required*) _____ Amount (*Required*) _____ Run Date (*Required*) _____ Amount (*Required*) _____

☐ **Warrant Tracer** (Lost Checks)

Warrant Date (Not Run Date) _____ Warrant # (*Required*) _____ Warrant Amount (*Required*) _____

Warrant Date (Not Run Date) _____ Warrant # (*Required*) _____ Warrant Amount (*Required*) _____

Warrant Date (Not Run Date) _____ Warrant # (*Required*) _____ Warrant Amount (*Required*) _____

☐ IHC Access Request

☐ **Fee Schedule Request** **TM** **NTM** **PCN** **(Select program which applies)**

____ Physician ____ Medical Supply ____ Physical Therapy Other:_____
____ Dental ____ Home Health ____ Audiology (please specify)
____ Vision ____ Transportation ____ Podiatry

☐ **Publication/Form Request**

_____ Direct Billing Transmittal
_____ LTC-1 (Turnaround Document)
_____ 499-A Sterilization / Hysterectomy Consent
_____ Medicaid Information Bulletin Number (or Name): _____
_____ PA-3 Prior Authorization
_____ Disclosure of Information (Client) To/From (Circle)
_____ Other Publication: _____

Manuals listed on back of form

Return Document Request Form by mail or fax to:

Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106

Fax: (801) 536-0476

CHECK PLAN REQUESTED

_____TRADITIONAL MEDICAID PLAN _____ NON-TRADITIONAL MEDICAID PLAN _____ PRIMARY CARE NETWORK (PCN)

INDICATE TYPE OF MANUAL/SECTION BY CIRCLING OR A CHECK

_____Table of Contents/Welcome _____ Section 1 _____ Section 2,3,4 _____ General Attachments

Audiologist
Child Health Evaluation Care: CHEC
Certified Nurse Midwife
Chiropractor
Dental Care
Diagnostic & Rehabilitative Mental Health Services by DHS Contractors
Enhanced Services for Pregnant Women
Home and Community Waiver Programs for Individuals
- Aged 65 and over
- With Brain Injury, Age 18 and Over
- With Developmental Disabilities/Mental Retardation
- With Physical Disabilities
- Technology Dependent Children

Home Health Agency
Hospice
Hospital (includes Birthing Center, End Stage Renal Disease, Free-standing Ambulatory Surgical Center)
Laboratory
Long Term Care
Medical Transportation
Medical Supplies
Mental Health Center
Occupational Therapy Services by an Independent O.T. NOT in a Rehabilitation Center
Oral Surgeon
Personal Care
Pharmacy
Physical Therapy and Occupational Therapy Services in a Rehabilitation Center
Physical Therapy Services by an Independent P.T. NOT in Rehabilitation Center
Physician (includes Anesthesiology, Laboratory Services)
Podiatric Services
Psychologist
Rural Health Clinic
School Based Skills Development Services
Speech Pathology
Substance Abuse Services Provider
Targeted Case Management Programs for:
- AIDS Patients
- CHEC Eligibles
- Chronically Mentally Ill
- Early Childhood Development
- Homeless
- Substance Abuse Services

Vision Care

**Manuals are available on the Internet at http://www.health.utah.gov/medicaid/

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